Frequently Asked Questions from the DDaP Provider Forums, May 8, 2009

DDaP Development Process

Q: Will you tell us what you decide after meetings like this?
A: Yes, we will produce a Frequently Asked Questions (FAQ) document and update it as needed.

Q: Can we get an explanation of the categories so that they have more meaning for people? (I.e. providers, clients) For example, explain which items are defined by the federal government and thus cannot change?
A: DMHAS will produce materials that explain these data elements.

Q: Can we get a detailed analysis of what is currently being collected versus what will be, with justification for all elements?
A: Yes, this will be produced along with the data element explanations.

Q: Current contracts have outcome measures that do not really match what's in the current data system- how will this issue be addressed?
A: DMHAS is moving to standardize measures across programs/levels of care with some exceptions. These measures will also be included in the report cards. We will likely be incorporating new measures into contract language in December of FY10.

Q: Is DMHAS going to help fund providers for these changes?
A: We believe that there will be up to $3000 per agency per set of major changes. Correspondence to this effect will be issued from the commissioner's office in the next week or so.

Q: What assurance will we have that we won't have to keep making continual changes to our data systems?
A: DMHAS hopes to institute a policy of requiring data element/system changes once per year, similar to the way that the Fiscal unit handles contract changes. This will allow for ample time to notify providers and for implementation. Once the final requirements are set for DDaP, they will not change, because the system will be built to those specifications.

Q: Is there a way to make DDaP capable of importing data from the data system for homeless clients?
A: This is an issue that has come up repeatedly over the years. We will check with Statewide Services to see if there might be a solution.

Workflow Issues

Q: My agency spends a large amount of time entering data because clients are stepping down, within the agency, from detox to partial hospitalization. This requires us to enter a number of data elements repeatedly. Is the new system going to require still more data entry?
A: This appears to be a workflow issue. How can we facilitate the data flow so that it is efficient and doesn't require double keying? We will examine this.

Q: How can we get credit for doing a good job with engagement? For example, we may get a referral to our housing from CVH. We then spend 3 months engaging the client before they are released. When is the referral date? And will the length of time count against us?
A: This issue will need to be examined carefully.

Q: How can we document no shows/cancellations/rescheduled appointments in the context of connect to care measures? How about the existence of a waiting list- client is ready to be referred, but space not available yet?

and

Q: We are an agency that provides multiple levels of care that people move through. What is considered the date of the first service request?
A: These issues need further analysis based on the discussion in the forum.

Q: Will case management time recording change? Will all services have to be entered at the individual level? (Similar questions for residential and other levels of care.)
A: These questions regarding time recording will need to be considered further.

Q: Will agencies have to update veteran data going back in time (regarding dates of service?)
A: We will research this.

Q: Which will be better? Individual data entry or batch data submissions?
A: Ultimately, this will be a decision for the agency to make, based upon individual circumstances. There is no "one size fits all" solution; the data submission options are designed to allow providers to pick the one that best suits their business.

Periodic Updates/Interval Reporting

Q: We are already sending periodic updates with our data extracts now- how will the new process differ?
A: There will be no restriction on the amount of updates that a provider can send for key fields. We are establishing a baseline, because some providers are not accustomed to sending periodic updates at this time. There will be date fields associated with the fields that are to be periodically updated.

Q: We send periodic updates regularly- will we have to change our schedule to meet DMHAS' timeline?
A: The periodic update process will need to fit in with the agency's natural process of updating, which more than likely already occurs in agency records, and are simply not transmitted to DMHAS at this time. DMHAS will not be imposing an arbitrary timeline.

Protocols and Requirements

Q: Will vocational providers or clubhouses have to enter all the new substance abuse data elements?
A: Probably admission/discharge/service, but there may be other things- want to think through exclusions over the next few months (at this time, voc doesn't have to submit full SATIS)

Q: Will protocol change for when a methadone client is already enrolled in a methadone program at another agency? Right now it is cumbersome to rely on DMHAS staff to get the client discharged.
A: This will not change, as DMHAS must adhere to federal laws concerning methadone treatment.

Q: Do providers have to submit diagnosis data for each row of data?
A: Yes. This should be a simple task.

Q: Will there be any changes in reporting methadone services?
A: Not at this time.

Data Elements

Q: Please identify the data elements that are new for mental health providers as well as new for everyone.
A: A list will be produced soon and circulated.

Q: In current Unknown Values reports, the "unknown" option can reflect a provider's inability to provide information. We get a lot of refusals on key elements such as religion, race, and ethnicity. Can we have an option like "prefer not to specify"?
A: We will examine this option.

Q: Some clients can't remember the ZIP codes or their last address. What should we do?
A: Probably best to get the town and then look up the ZIP code as best you can.

Q: Regarding military service- instead of the exact date, can we enter the year or "can't remember"?
A: We may change this to month and year. Additionally, there are some resources you can use to get key military service dates. Discharged veterans are issued the DD214 (discharge papers and separation documents) which contain dates of service. Additionally, the VA will confirm dates over the phone.

Q: How should we code common law spouses?
A: Common law marriage is not a legal status in Connecticut. The person should be coded from the choices in the pick list.

Q: Why isn't internal referral a referral source?
A: We are already able to look at internal referral patterns. The point of the referral source is to examine how quickly people get into services.

Q: Can DMHAS and DCF work together to consolidate referral lists and to share a common format for race, ethnicity, and language?
A: We are working with a federally produced data elements, but we may be able to create something that works better and incorporates some common items.

Q: Can we try for some commonality with CSSD data elements?
A: The federal government is trying to work on a minimum data set, but right now we may not be able to do this well.

Q: What do we do if the client has multiple sources of support?
A: We recommend that you enter the primary source of support.

Q: Can we get a detailed description of the difference between unemployed and not in labor force? In MH services, volunteering is very important and considered unpaid employment.
A: We will produce this with the other descriptions requested.

Q: Regarding living situation – we need to be able to show improvement through changing housing status
A: We will examine this some more.

Q: Which data elements will be required for interval reporting?
A: DMHAS will produce a list.

Q: Will the added SA items have to be completed for all MH clients?
A: No- these items are germane only for the clients who have a SA diagnosis.

Q: Will there be acceptable duration ranges for each service code that are validated by the application?
A: The DDaP validation will try to distinguish between services measured in minutes and services measured in days, although this issue needs further consideration.

Q: Some staff providing TCM services are not clinicians. You should change the data label.
A: We will take this under consideration.

Q: Is the episodic or interval data essentially the same fields as admission and discharge, except that these fields have dates associated with them?
A: Yes, they are the same fields as before.

Q: Why not just collect ZIP codes instead of town name and ZIP?
A: It would be good to have a validation of the town name with a pick list- some people don't remember ZIP codes.

Q: Should pregnancy status be periodically updated as well?
A: If relevant, it could be. The federal government seems to care about this only at admission at this time.

Q: Number of days homeless might be inadequate and difficult to obtain. How about "Have you been homeless in the last 6 months?" Also, need a standard definition of homeless.
A: We will examine these issues further.

Q: Is the number of arrests required? Can this be a yes/no question?
A: We will double check to see if there is any flexibility with this and the homelessness question.

Q: Can nicotine be added as a substance? It shows up in diagnoses a great deal.
A: DMHAS' standard operating procedure is to use the federal values for NOMs/TEDS data elements where possible, and nicotine is not included in these values.

DDaP System

Q: What are the new file types?
A: Delimited text or 837 format.

Q: Will DMHAS provide a crosswalk to the 837?
A: Yes.

Q: Is there a specific deadline for DMHAS to provide final core data requirements to the provider community?
A: September 1, 2009.

Q: Will DDaP limit users' access to the program level, so that they only have access to data relevant to them?
A: Yes. This functionality is actually present in DPAS.

Q: Will the Prevention data system be incorporated into DDaP?
A: No; nor will the Shelter + Care database, because neither are on the client level.

Q: Will agency staff access to DDaP be limited?
A: No. DOIT has been issuing tokens to everyone who has requested them, and DMHAS has been reviewing applications and approving most. This applies to fiscal staff who may be entering AFR data as well.

Q: Will DDaP support mixed data entry (i.e. data entry of individual records and batch processing)?
A: Yes.

Q: How long will it take to upload a file through DDaP?
A: This is not known yet because the system is not yet built, but it should not take more than a few minutes.

Q: Is this really going to be different from DPAS? Will DPAS be gone completely?
A: DPAS will be replaced by DDaP. DDaP will start in a similar manner to DPAS, in that you will use your token and log in through a web interface. However, unlike the current system, which launches a new Visual Basic program, DDaP will work in your web browser window.

Q: Will existing data in DPAS be migrated to DDaP?
A: Yes.

Q: Will a new paper form be developed for use by providers if they wish?
A: Yes, DMHAS will develop forms for admission, discharge, and periodic updates.

Q: Could initial assessment information be populated to subsequent updates?
A: We think so, and will look into this. The question here is – if data is automatically carried forward, will there be a temptation to not update it? This needs to be examined further.

Q: How would a provider produce a file to submit periodic updates by interface?
A: Calculated service dates or touch dates would trigger updates in a query. The provider system would have to build in the update flags/triggers.

Q: When a batch file is processed in the new system, will errors be able to be corrected right away? Will providers have the ability to drill down to individual records?
A: Yes, and yes. Records that are not immediately corrected will remain in a correction queue.

Q: Why would you want to store certain elements at the program level when it is possible that the client is in multiple programs at an agency? This causes duplication of data entry.
A: There should be coordinated treatment planning at agencies such as this, which would help prevent differing values being entered, but the data entry issue is something that should be looked at further.

Q: What is the point of agency planning now if the dataset is not totally finalized?
A: There are certain things that agencies can do now to prepare- for example, mental health agencies can review to see if they are collecting substance abuse data presently.

Reporting

Q: Can providers submit their own client ID to use as a key for later extract and analysis?
A: Yes, there will be a field specified for this purpose.

Q: Since we are being asked for interval reporting, will we be able to produce reports for these intervals?
A: Yes.

Q: Will this system give better flexibility for reporting?
A: Reporting will be built into DDaP. Provider input on report designs is welcomed and appreciated at this time. At this point, we know that we will have reports that will offer counts, demographic information, diagnostic information, and data about connecting to care. We will produce a roster of reports and offer it to the provider community for feedback.

Q: Will we be able to download the information that we submit to DDaP, for our own analyses?
A: This should be possible through the reporting utility, as it is with the SATIS data download.

Q: Suggestion to get a copy of the DCF/Value Options connect to care measures that have been used for a few years
A: (We requested that the asker send this information to Jim Siemianowski.)

Q: Paul DiLeo told a CAN meeting that the first report cards will be issued in November. Please explain.
A: We are looking at this year as a transitional year, where we start issuing reports but will not hold providers to them till we are all certain that the reports are measuring what we find most useful and are working as they should.

Critical Incidents

Q: Regarding critical incident reporting in DDaP- would this data entry be in addition to the current process?
A: No. The data entry will replace the initial written/faxed report. However, in some cases, the phone call will still be essential- such as for client deaths. We will be more specific regarding this protocol when we get closer to implementation.

Q: Can critical incident data entry protocol be negotiated by LMHA? Region 5 prefers to handle all critical incident reporting.
A: Yes, this will be discussed in a meeting with LMHA QI Directors.

Q: Will providers be able to obtain reports and download access to their own critical incident data?
A: This should be possible and we will explore this.

Consumer Survey, Jail Diversion, Crisis

Q: Is crisis going to remain direct data entry?
A: At this time, yes. Support for batch processing may be added in a later phase.

Q: Will there be capability to upload Consumer Survey/Jail Diversion/Crisis data in batches, instead of through individual data entry?
A: Unfortunately, this function will not be supported in Phase I of DDaP. It could, however, be covered in Phase 2.

Q: Why is it a good thing to have provider-specific critical incident information online?
A: Having the incident data online allows for a common place for annotation, updating, and notification. We will continue to refine this process and welcome input from the provider community.